Client Intake Form – Massage

Grit with Grace
Wellness and Healing

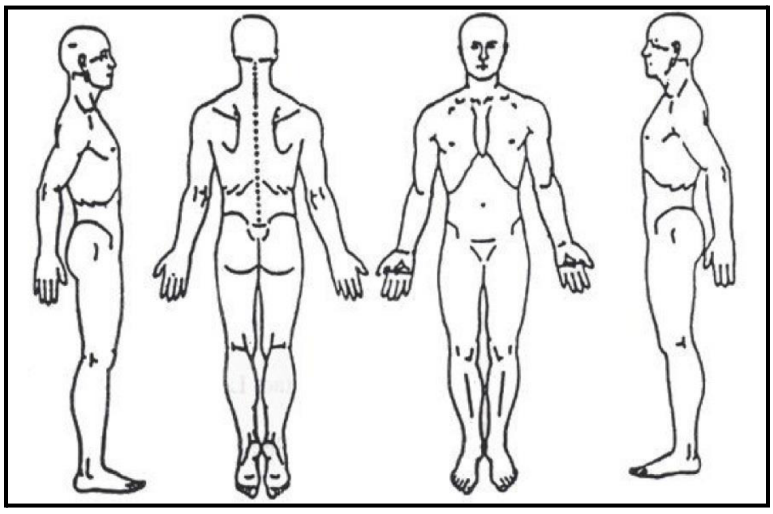
Date: _____ Occupation: _____
Name: _____ Phone Number: _____
Date of birth: _____ Email: _____

1. Would it be ok to follow up with promotions on services you received in the past? Yes/No
2. Have you ever had a massage before? Yes No
   If yes, how often: _____
3. What are your goals for seeking Massage therapy? _____
4. What type of pressure do you like? Light to Medium or Medium to Firm
5. Have you had any surgeries or injuries I should know of? Yes No
   If yes, please describe: _____
6. Are you sensitive or allergic to any fragrances, oils or lotions? Yes No
   If yes, please list: _____

Please check any conditions listed below that applies to you:

( ) Open sores or wounds
( ) Easy bruising
( ) Artificial joint
( ) Current fever
( ) Swollen glands
( ) Heart condition
( ) High or low blood pressure
( ) Circulatory disorder
( ) Varicose veins
( ) Deep vein thrombosis/blood clots
( ) Rheumatoid arthritis/osteoarthritis
( ) Limited range of motion
( ) Epilepsy
( ) Headaches/migraines
( ) Cancer
( ) Diabetes
( ) Decreased sensation
( ) Fibromyalgia
( ) Contagious skin condition
( ) Pregnant (If yes, how many months?_____)

Please circle any specific areas you would like the massage therapist to concentrate on during the session:



I have provided all related medical information, I understand that the purpose of this massage is for relaxation only. I understand that massage therapists will not provide medical diagnosis.

Clients Signature: _____